



Client Information Form

Date _____

Client Name _____ Male/Female _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

May we leave a message at your home phone? *(Please feel free to leave comments.)*

Yes No _____

Date of Birth _____ Student Status: Full Time Student Part-Time Student Non-Student

Who referred you? _____ Phone: _____

Required Signature

I understand all payments and co-payments are due at the time service is rendered by check, cash, or credit card. I understand that unless paid in full at the time of service, I assign any insurance benefits accrued to me to Legacy Clinical Consultants, LLC. I understand I am responsible for payment regardless of whether I am reimbursed for those services. I understand if I fail to provide at least 24 hours advance notice of cancellation of a session, I am responsible for payment in full for the missed appointment.

Guarantor Signature: _____

This section pertains to children/adolescent clients:

School _____ Grade _____

Please indicate if we may leave messages at these numbers. *(Check One)* Yes or No and Initial here: _____

Parents in household:

Name _____ Day Phone _____ Y N

Cell Phone _____ Y N Evening Phone _____ Y N

Name _____ Day Phone _____ Y N

Cell Phone _____ Y N Evening Phone _____ Y N

Birth Parent not in household:

Name _____ Day Phone _____ Y N

Cell Phone _____ Y N Evening Phone _____ Y N

Siblings living at home or away:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____